December 1996
WEST VIRGINIA INFORMATIONAL LETTER
NO. 103

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS AND ALL APPLICANTS SEEKING CERTIFICATES OF AUTHORITY AS HEALTH MAINTENANCE ORGANIZATIONS

RE: HEALTH MAINTENANCE ORGANIZATION APPLICATION GUIDELINES AND CHECKLIST FOR CERTIFICATE OF AUTHORITY

West Virginia Code § 33-25A-3a(3) provides that effective June 7, 1996, all certificates of authority issued to health maintenance organizations expire at midnight on May 31 of each year. To assist in the 1997 renewal process, as well as with an initial application procedure, this Office has developed the enclosed "Health Maintenance Organization Application Guidelines and Checklist for Certificate of Authority."

This form, along with all requested information and documentation, must be completed and submitted to the Commissioner with each application for a certificate of authority or for renewal of a certificate of authority. In the application process for a renewal of a certificate of authority, health maintenance organizations may describe relevant documents previously filed with this Department. Incomplete items or items not previously filed should accompany the renewal application. Additionally, if any of the original organizational documents have been modified, copies of the Commissioners approval of all such changes should be filed. Also, the requested information information and documental regarding a feasibility study should only be submitted with an application for an initial certificate of authority; this information is not required in the renewal process. Please note that the certificate of authority renewal process is not a substitute for nor in lieu of holding company filings or major modification filings.

While the Commissioner is required to issue or deny a certificate of authority within one hundred twenty days after receipt of the completed application, an application will not be considered complete until all required information and documentation has been submitted. Completed applications and accompany documentation are to be mailed to:

West Virginia Insurance Commission
Financial Conditions Division
P.O. Box 50540
Charleston, West Virginia 25305-0540

Please direct any questions regarding the Grievance Procedure to the Consumer Services Division. Questions concerning Quality Assurance should be directed to the Consumer Advocacy Division. All other questions regarding the "Health Maintenance Organization Application Guidelines and Checklist for Certificate of Authority" should be directed to the Financial Conditions Division.

Hanley C. Clark
Insurance Commissioner

STATE OF WEST VIRGINIA
INSURANCE COMMISSIONER

HEALTH MAINTENANCE ORGANIZATION APPLICATION GUIDELINES AND CHECKLIST FOR CERTIFICATE OF AUTHORITY

CHAPTER 33, ARTICLE 25A OF THE WEST VIRGINIA CODE

☐ Initial Application ☐ Major Modification ☐ Renewal for Year Beginning June 1, 19___

Mail Completed Application to:

West Virginia Insurance Commission
Financial Conditions Division
P.O. Box 50540
Charleston, West Virginia 25305-0540

Pursuant to Chapter 33, Article 25A, of the West Virginia Code, the application is hereby submitted to form and operate a Health Maintenance Organization ("HMO").

Name, trade name and address of the Health Maintenance Organization Applicant:

NAME: _____

TRADE NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

PHONE: (_____)_____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION ON BEHALF OF THE HMO APPLICANT:

NAME: _____

ADDRESS: _____

STATE: _____ ZIP CODE: _____

PHONE: (_____)_____

INTRODUCTION

A Health Maintenance Organization (HMO) is a public or private organization which provides or otherwise makes available basic health care services to enrollees. Factors to consider in determining if an organization is an HMO include, but are not limited to, whether it: (1) receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis excluding copayments; (2) provides physician services through doctors who are either employees or partners of the organization and/or through arrangements with individual or group practice doctors; (3) assures the availability, accessibility, quality and effective utilization of the health care services which it provides; and (4) offers services through an organized delivery system in which a primary care physician is designated for each subscriber upon enrollment.

To operate in West Virginia, an HMO must apply for and receive a Certificate of Authority from the Insurance Commissioner. Each application must set forth and be accompanied by the information and documentation requested. The Commissioner shall issue or deny a Certificate of Authority to any person filing an application within one hundred twenty days after receipt of the completed application. **IMPORTANTLY: An application will not be considered complete until all information and documentation requested have been submitted to the Commissioner, and the applicant has fully complied with all provisions or requirements of these guidelines or applicable laws**. Prior to receiving a Certificate of Authority, an applicant will be contacted by the Insurance Commission to initiate the depositing of cash or government securities with the West Virginia Treasurers Office in compliance with W. Va. Code § 33-25A-4(2)(h).

INSTRUCTIONS

1. A completed application checklist and appropriate verification must be submitted.

2. All information provided should be placed in three-inch binder(s) and be separated by numbered tabs which correspond to the numbered requests in the application checklist. For example: Application Question No. 5 asks for a copy of the Articles of Incorporation. The copy should be placed under Tab No. 5 in the binder.

3. Documents must have page numbers which should begin with the corresponding Tab No. and a dash (-). For Example: If the Articles of Incorporation are four pages long, each page should be numbered 5-1, 5-2, 5-3 and 5-4.

4. Replacement pages should specifically note what pages are being replaced. For example: If the Articles of Incorporation were incorrect and had to be replaced, they should be numbered Replacement 5-1, Replacement 5-2, etc. If the documents merely supplement existing documents, they should be marked Supplement and should use a letter of the alphabet. For example: If page 5-1 of the Articles of Incorporation is being supplemented it should be numbered Supplemental 5-1(a).

5. Each application box should be checkmarked (√) if the information has been provided.**REMEMBER**: Each application must be verified to make sure that the documents and information have been provided before completing and sending the checklist and verification.

6. Page numbers indicating the information and/or document location(s) must be clearly marked on the space provided.

NOTE: The information requested by the Application Checklist constitutes the minimum necessary to begin the 120-day Certificate of Authority review cycle. The Commissioner reserves the right to ask for and obtain additional information and/or documents from an applicant at any time prior to the deemer date in order to determine whether to grant a Certificate of Authority.

I. CERTIFICATE OF AUTHORITY

Page(s)
Location

☐ __ 1. Each application for a Certificate of Authority must be verified by an officer or authorized representative of the applicant.

- ☐ __ a. A verification form entitled "CERTIFICATION" is included with this application packet and must be completed and filed with each application.
- ☐ __ b. Attach a copy of the corporate resolution appointing the individual as the authorized representative of the HMO.

☐ __ 2. Complete the enclosed "HEALTH MAINTENANCE ORGANIZATION APPLICATION FOR A CERTIFICATE OF AUTHORITY FILING FEE REMITTANCE FORM."

- ☐ ___ Attach a check in the amount of $200 made payable to the "Insurance Commissioner of West Virginia."

☐ ___ 3. File an **original and two copies** of the application with the West Virginia Insurance Commissioner. The Commissioner may request additional copies.

☐ ___ 4. File a copy of page 1 of this application with:

Marianne K. Stonestreet, General Counsel
Health Care Cost Review Authority
100 Dee Drive, Suite 201
Charleston, WV 25311-1692

II. ORGANIZATIONAL/MANAGERIAL

☐ ___ 5. Submit Articles of Incorporation and all amendments certified by the Secretary of State.

- ☐ ___ a. The Articles of Incorporation must state that the applicant will operate as a Health Maintenance Organization.
- ☐ ___ b. The Secretary of States certificate must be dated no later than thirty (30) days before the first submission of this application.

☐ ___ 6. List and submit a copy of each type of security issued by the applicant to acquire necessary start-up capital.

☐ ___ 7. State the amount of applicants and/or surplus:

- ☐ ___ a. For profit stock corporation:
  - ☐ ___ Fully paid-in capital stock (at least $1,000,000) $_____
  - ☐ ___ Additional surplus (at least $1,000,000) $_____
- ☐ ___ b. For non-profit corporation:
  - ☐ ___ Statutory surplus (at least $1,000,000) $_____
  - ☐ ___ Additional surplus (at least $1,000,000) $_____

☐ ___ 8. Submit in chronological order a legal history listing predecessor corporations and/or organizations, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved.

☐ ___ 9. Submit a copy of the Bylaws, rules and regulations or similar document regulating applicants conduct.

☐ ___ 10. Submit a statement declaring that the applicant's books and records shall be maintained within West Virginia and providing the location thereof unless otherwise specified by Administrative Order of the Commissioner. The books and records to be kept include:

- ☐ ___ a. Original Articles of Incorporation and By-Laws with all changes and amendments to both instruments;
- ☐ ___ b. Copies of all correspondence with the Commissioner and the Secretary of States Office covering the filings of the documents listed in § a. above;
- ☐ ___ c. All corporate correspondence;
- ☐ ___ d. All stockholders records including a list of stockholders or a copy of stock certificates if the HMO is a wholly owned subsidiary and a separate listing of stockholders by officers and directors;
- ☐ ___ e. The names, addresses and principal occupations of all directors of the HMO;
- ☐ ___ f. A listing of the various committees and include committee functions and the names of all members;
- ☐ ___ g. Records showing compensation, fees and expense allowance received by each director and/or officer;
- ☐ ___ h. Minutes of all meetings of shareholders or policyholders, directors and committees;
- ☐ ___ i. Copies of any agency, management, service, employment or other contracts between current companies or personnel;
- ☐ ___ j. Copies of any contracts, consultant or retirement arrangements with former officers, directors or employees with any stock option plans in existence;
- ☐ ___ k. Any inter-company agreements;
- ☐ ___ l. Copies of expense sharing arrangement - percentages and method of allocation together with other pertinent data;
- ☐ __ m. Organization chart if company is part of a holding company system, together with copies of all Insurance Holding Company Filings;
- ☐ ___ n. Name and other necessary information concerning the company's or the holding company's stock transfer agent;
- ☐ ___ o. A description of the mechanisms by which enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to W. Va. Code § 33-25A- 6;
- ☐ ___ p. Enrollees' advisory panel minutes;
- ☐ ___ q. All policy (enrollee forms) forms and related documents;

☐ ___ r. Agency correspondence;

☐ ___ s. Trial Balances;

☐ ___ t. General Ledgers;

☐ ___ u. Sub-Ledgers;

☐ ___ v. General Journals;

☐ ___ w. All account reconciliations;

☐ ___ x. Reconciliations of all filed statements to General Ledger;

☐ ___ y. Bank Statements with canceled checks;

☐ ___ z. Broker Statements;

☐ ___ aa. Broker Confirms/Advices;

☐ ___ bb. Claim Documents/Benefit files;

☐ ___ cc. Claims -Ledger/Registers/payment listings, code sheets, correspondence and all related worksheets;

☐ ___ dd Complaint Registers;

☐ ___ ee. Reinsurance records and agreements;

☐ ___ ff. Petty cash; and

☐ ___ gg. All supporting accounting records

☐ ___ 11. Submit the names, addresses and official capacities of all officers, directors, managers, administrators and persons holding 5% or more of the common stock of the organization responsible for the applicants conduct.

☐ ___ a. Include a completed BIOGRAPHICAL STATEMENT AND AFFIDAVIT for each name listed above.

☐ ___ b. Each individual named above must fully disclose to the Insurance Commissioner and the applicants Board of Directors the nature and extent of all contracts or arrangements with the applicant. The disclosure shall include any and all possible conflicts of interest.

☐ ___ c. Persons holding 5% or more of the applicants common stock must disclose the nature and extent of any ownership interest in all parent organizations, subsidiaries and affiliated companies. The disclosure must include an organizational chart depicting all levels of ownership including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

☐ ___ d. Submit independent investigation reports on all individuals identified above.

1. The reports must be forwarded directly to the Financial Conditions Division of the Offices of the West Virginia Insurance Commissioner from the independent investigations.
2. Person(s) required to furnish an investigation report may use:

☐ Equifax Services, Inc.
P.O. Box 2729
Jacksonville, FL. 32203
(904) 733-7550

☐ Another investigative organization approved by the Insurance Commissioner prior to the filing of the application.

☐ ___ 12. Submit a statement describing:

☐ a. Proposed operations.

☐ ___ 1. State whether the applicant will be a Staff Model, IPA Model or Combination Model HMO.

☐ ___ 2. Describe the method of compensation for providers, e.g. fee-for-service, capitated, etc.

☐ b. The proposed service area(s). "Service area" means the county or counties to be approved by the Commissioner within which the applicant may provide or arrange for health care services for its subscribers.

III. MARKETING

13. Describe the marketing strategy for each major category of enrollment.

☐ ___ Group

☐ ___ Criteria for selection of primary and secondary targets;

☐ ___ Use of underwriting guidelines;

☐ ___ Plans for community education and public relations

☐ ___ Small Group

☐ ___ Criteria for selection of primary and secondary target;

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

☐ ___ Individual

☐ ___ Criteria for selection of primary and secondary target;

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

☐ ___ Medicare

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

☐ ___ Medicaid

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

☐ ___ Public Employees Insurance Agency

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

☐ ___ Other

☐ ___ Criteria for selection of primary and secondary target;

☐ ___ Use of underwriting guidelines

☐ ___ Plans for community education and public relations

IV. INSURANCE

☐ ___ 14. Describe any limitation of the applicant's financial risk. An HMO may either obtain reinsurance or make other arrangements acceptable to the Commissioner.

- ☐ ___ For the cost of providing to any enrollee health care services the aggregate value of which exceeds $4,000.00 in any year;
- ☐ ___ For the cost of providing health care services on a non-elective emergency basis or for coverage outside the service area; or
- ☐ ___ For not more than 95% of the amount by which the applicant's costs for any of its f fiscal years exceed 105% of its income for those fiscal years.
- ☐ ___ Other

☐ ___ 15. Describe any risk sharing arrangements with provider(s) or other parties. Provide a copy of and reference the applicable sections of each provider contract pertaining to the risk-sharing arrangements. See 114 WVCSR 43.

☐ ___ 16. All directors, officers, administrators, persons holding 5% or more common stock of the employees who receive, collect, disburse or invest funds in connection with the HMO must be appropriately bonded.

- ☐ ___ Submit the enclosed "FIDELITY BOND WORKSHEET" (Form HMO-FID-1).
- ☐ ___ Obtain fidelity bond(s) in the amount prescribed by the worksheet
- ☐ ___ Submit a copy of each fidelity bond obtained. Each bond must be current and must be relevant to applicants proposed operations.

☐ ___ 17. Describe any arrangements to guarantee the continuation of benefits and payments to providers of services rendered to and after insolvency for the duration of the contract period for which premiums have been paid or until their discharge for members confined to an inpatient facility on the date of insolvency.

V. FEASIBILITY STUDY

☐ ___ 18. Submit a comprehensive feasibility study:

- ☐ ___ a. Performed by a qualified independent actuary in conjunction with a certified public accountant;
- ☐ ___ b. Containing certification by the qualified actuary as to the feasibility of the proposed organization;
- ☐ ___ c. Containing an opinion by the certified public accountant as to the feasibility of the proposed organization;
- ☐ ___ d. Covering the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months;
- ☐ ___ e. Demonstrating that the HMO would not, at the end of any month of the projection period, have less than the minimum capital and surplus;
- ☐ ___ f. Stating that the rates are not inadequate, excessive or unfairly discriminatory;
- ☐ ___ g. Demonstrating that the rates are appropriate for the classes of risk for which they have been computed;

☐ ___ h. Outlining the appropriate rating methodology;

☐ ___ i. Demonstrating the HMO is actuarially sound:

☐ ___ 1. The certification shall consider the rates, benefits and expenses of the organization.

☐ ___ 2. The rates that are or will be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

☐ ___ 3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided; and

☐ ___ j. Indicating that the HMO is knowledgeable about the competitors, market and service areas for the geographic location(s) where it will operate.

VI. FINANCIAL

☐ ___ 19. The applicant must demonstrate in writing and by documentation that:

☐ ___ a. It will have adequate funding to continuously meet the minimum capital and surplus requirements as set forth in W. Va. § 33-25A-4(2)(c)(ii).

☐ ___ b. The source of funding and nature of all income, expenses and capital items through break-even.

☐ ___ 20. Submit a statement of the proposed initial cash and cash reserves summary. This should be inclusive of all:

☐ Loan receipts

☐ Loan repayments

☐ Stock sales

☐ Surplus notes

☐ Other

☐ __ a. Describe the sources and terms of the funding.

☐ ___ b. Submit independently certified audited financial statements of all guarantor(s).

☐ ___ 21. Submit a statement declaring all investments have been valued for asset purposes on a basis currently approved by the National Association of Insurance Commissioners (NAIC). If any investments have been valued for asset purposes in a manner other than one currently approved by the NAIC, describe each item so valued and the basis of value indicated on the "Asset Page" of the balance sheet

☐ ___ 22. Submit a statement that all investments valued for asset purposes are maintained and/or located in West Virginia financial institutions.

VII. ENROLLMENT

☐ ___ 23. Submit a description of the following assumptions underlying enrollment projections:

☐ ___ A projection of enrollment;

☐ ___ Number of eligible persons residing within the service area;

☐ ___ Contract size assumptions (contract distribution and content);

☐ ___ Penetration assumptions and rationale, including initial and re-enrollments;

☐ ___ Allowance for voluntary/involuntary disenrollment and group contract additions during the year;

☐ ___ Projection by month and year of the break-even date; and

☐ ___ A plan outlining the provisions made for emergency and out-of-area health care.

VIIL CONTRACTUAL

☐ ___ 24. Submit copies of all:

☐ ___ Enrollment contracts.

☐ __ Member handbooks.

☐ ___ Benefit packages, riders and endorsements. At a minimum, benefits shall include:

☐ ___ TMJ

☐ ___ CMD

☐ ___ Mammography

☐ ___ Pap Smears

☐ ___ Rehabilitation

☐ ___ Child Immunizations

☐ ___ Basic Health Care Services as defined in W. Va. Code § 33-25A-2(1).

☐ ___ 25. Submit a copy of each type of provider contract utilized by the applicant The contracts must include:

☐ ___ Hold Harmless Clause (see recommended HMO Hold Harmless language attached hereto).

☐ ___ Sixty day notification to the HMO and Insurance Commissioner prior to termination of the contract.

☐ ___ Note: If documents are intermediary contracts, provide evidence that the HMO has met all other requirements contained in WVCSR § 114-43-3.

☐ ____26. Submit a list of all physicians, hospitals and other providers with whom the applicant has contracted for services and the corresponding signature pages from each executed provider contract. The list and the corresponding signature pages must be alphabetized and sorted by county and specialty.

IX. GRIEVANCES & APPEALS

☐ ___ 27. Submit a detailed description of applicants subscriber grievance and appeal procedures and include a statement that the HMO shall have someone with decision-making authority at each level of the process.

☐ ___ 28. Provide samples of group and individual contracts and certificate or member handbooks given to subscribers. Each shall include:

- ☐ __ a. Formal and informal steps to resolve grievances;
- ☐ ___ b. Toll-free telephone numbers for the subscriber to call to present an informal grievance or to contact the grievance coordinator;
- ☐ ___ c. An address for written grievances;
- ☐ ___ d. A detailed description of the appeal process;
- ☐ ___ e. A description of the statute of limitations for filing grievances;
- ☐ ___ f. A statement outlining the time frame in which grievances shall be processed;
- ☐ ___ g. A statement that there is physician involvement in the review of medically-related grievances; and
- ☐ ___ h. A statement that time sensitive grievances will be handled on an expedited basis.

☐ ___ 29. Submit a copy of the policies and procedures for administering formal and informal grievances.

☐ ___ 30. Provide the name, address and telephone number of the grievance coordinator(s) who is/are responsible for the implementation of the grievance procedure.

X. QUALITY ASSURANCE

☐ ___ 31. To establish quality management and improvement provide:

- ☐ __ a. Written description of the Quality Improvement (QI) program that outlines program structure and design.
- ☐ __ b. Statement that description is reviewed annually and updated as necessary.
- ☐ __ c. Name, address and telephone number of senior executive responsible for program implementation.
- ☐ __ d. Evidence that medical director has substantial involvement in QI activities.
- ☐ __ e. Evidence of a committee that oversees and is involved in QI activities.
- ☐ __ f. Description of the role, structure and function, including frequency of meetings, of the QI Committee.
- ☐ __ g. Evidence that providers participate actively in the QI committee.
- ☐ __ h. Evidence of contemporaneous records reflecting actions of the committee.
- ☐ __ i. A copy of the annual QI work plan, or schedule of activities, that includes the following:
  - ☐ 1. Objectives, scope, and planned projects or activities for the year;
  - ☐ 2. Planned monitoring of previously identified issues, including tracking thereof over time; and
  - ☐ 3. Planned evaluation of the QI program.

32. To establish accountability to the governing body provide:

- ☐ ___ a. Documentation that the governing body has approved the QI Committees overall QI program and the annual QI work plan.
- ☐ ___ b. Evidence that the governing body or designated committee receives regular written reports from the QI program delineating actions taken and improvements made.
- ☐ ___ c. Evidence that the governing body reviews a written annual report on the QI program.
- ☐ ___ d. Evidence that QI information is used in recredentialing, recontracting, and/or annual performance evaluations.

33. To establish coordination with other management activity provide:

- ☐ ___ a. Evidence that QI activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of member complaints and grievances.
- ☐ ___ b. Evidence of linkage between QI and other management functions of the managed care organization, e.g. network changes, benefits redesign, medical management systems, practice feedback to providers and patient education.

34. Provider contracts should contain or include:

- ☐ ___ a. Requirements to participate in QI activities are incorporated into all provider contracts and employment agreements. Contracts should specify that hospitals and other contractors will allow the managed care organization access to the medical records of their members.
- ☐ ___ b. Evidence of member participation in QI.
- ☐ ___ c . Evidence that the monitoring and evaluation of clinical issues reflect the population served by the managed care organization in terms of age groups, disease categories, and special risk status. Identify the following:
  - ☐ ___ 1. Services provided in institutional settings;
  - ☐ ___ 2. Services provided in noninstitutional settings, including but not limited to, practitioner offices and home care.
  - ☐ ___ 3. Primary care and major specialty services, including mental health.
  - ☐ ___ 4. High-volume, high-risk services, and the care of acute and chronic conditions.

35. To establish important aspects of care and service provide:

- ☐ ___ a. The process for periodically updating the practice guidelines.
- ☐ ___ b. The mechanism for communicating the practice guidelines to managed care organization providers has been implemented.
- ☐ __ c. How performance is assessed against the practice guidelines.

☐ ___ d. A description of the evaluation process for member continuity and coordination of care.

☐ ___ e. A description of mechanisms to detect under and over utilization.

36. To establish access to care and service provide:

☐ ___ A copy of the standards for the availability of or access to primary care providers, e.g., routine, urgent and emergency care.

37. ☐ ___ Describe the process for identifying members with chronic/high-risk illnesses and implementing appropriate programmatic responses.

38. To establish quality measurement and improvement provide evidence that HMO has developed quality indicators that are objective, measurable and based on current knowledge and clinical experience and are used to monitor and evaluate each important aspect of care and service identified.

☐ ___ a. Identify performance goals and/or a bench-marking process for each indicator.

☐ ___ b. Identify the appropriate methods and frequency of data collection for each indicator.

☐ ___ c. Evidence that results of evaluations are used to improve clinical care and service.

☐ __ d. The method of tracking areas for improvement to assure that appropriate action is taken and improvements are effective.

39. To establish utilization management provide:

☐ ___ a. Description of the UM program including policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

☐ __ b. Mechanism for updating the UM program description on a periodic basis.

☐ ___ c. Evidence that qualified medical professionals supervise review decisions where procedures are used for preauthorization and concurrent review.

☐ __ d. Evidence that a duly licensed physician conducts a review for medical appropriateness on any denial.

☐ __ e. Evidence that the managed care organization utilizes, as needed, licensed physician consultants from appropriate specialty areas of medicine.

☐ ___ f. Written utilization review decision protocols.

☐ ___ g. The mechanism for checking the consistency of application of criteria across reviewers.

☐ ___ h. The mechanism for periodically updating review criteria.

☐ ___ i. Description of information intake including pertinent clinical information and consultation with the treating physician.

☐ __ j. Evidence that reasons for denial notification of appeal process are clearly documented and available to the member.

☐ ___ k. Written policies and procedures to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs and devices.

☐ ___ l. Written policies and procedures for evaluating the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means.

☐ __ m. If any delegation of QI or UM activities to contractors, provide evidence of oversight of the contracted activity including:

- ☐ __ 1. the delegated activities;
- ☐ ___ 2. the delegates accountability for these activities;
- ☐ ___ 3. the frequency of reporting to the HMO;
- ☐ ___ 4. the process by which delegation will be evaluated;
- ☐ __ 5. approval of the delegates UM program; and
- ☐ __ 6. evaluation of the regularly specified reports.

40. To establish that a system of credentialing is in place provide:

☐ ___ a. A copy of the written policies and procedures for the credentialing process.

☐ ___ b. Evidence of a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.

☐ __ c. The name, address, telephone number and area(s) of practice of each practitioner who falls under the HMOs scope of authority and action.

☐ ___ d. Evidence that the initial credentialing process is ongoing and up-to-date and that HMO obtains review verification of the following:

- ☐ ___ 1. A current valid license to practice;
- ☐ ___ 2. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- ☐ ___ 3. A valid DEA or CDS certificate, as applicable;
- ☐ __ 4. Graduation from medical school and completion of a residency, or board certification, as applicable;
- ☐ __ 5. Work history;
- ☐ __ 6. Current adequate malpractice insurance according to the LIMOs policy; and
- ☐ __ 7. Professional liability claims history.

☐ ___ e. A copy of the form application for membership including a statement by the applicant regarding:

- ☐ __ 1. reasons for any inability to perform the essential functions of the position with or without accommodation;

☐ __ 2. lack of present illegal drug use;

☐ __ 3. history of loss of license and/or felony convictions;

☐ ___ 4. history of loss or limitation of privileges or disciplinary activity; and

☐ ___ 5. an attestation to the correctness/completeness of the application.

☐ ___ f. Evidence that the HMO requests information on the practitioner during credentialing and re-credentialing from the following recognized monitoring organizations:

☐ __ 1. National Practitioner Data Bank;

☐ ___ 2. State Board of Medicine; and

☐ __ 3. Medicare/Medicaid sanctioning

☐ ___ g. Evidence of an initial visit to each potential primary care practitioners office and to the offices of obstetricians/gynecologists and other high-volume specialists resulting in documentation of a structured review of the site and of medical record keeping practices to ensure conformance with HMOs standards.

☐ ___ h. Copies of written policies and procedures for the initial quality assessment of all health delivery organizations with which the HMO intends to contract.

☐ ___ i. Evidence of the periodic verification of credentials that is ongoing and up-to-date and implemented at least every two years.

☐ ___ j. Evidence that recredentialing, recertification, or reappointment process includes verification from primary sources of:

☐ ___ 1. current valid license to practice;

☐ ___ 2. clinical privileges in good standing at the hospital designated by the practitioner the primary admitting facility;

☐ ___ 3. a valid DEA or CDS certificate, as applicable;

☐ ___ 4. board certification, as applicable;

☐ ___ 5. current, adequate malpractice insurance according to the HMOs policy; and

☐ ___ 6. professional liability claims history.

☐ ___ k. Evidence that the recredentialing process includes a current statement by the applicant regarding:

☐ __ 1. inability to perform the essential functions of the position, with or without accommodation; and

☐ __ 2. lack of present illegal drug use.

☐ __ l. Evidence that recredentialing, recertification, or performance appraisal process includes review data from:

☐ 1. member complaints;

☐ 2. results of quality reviews;

☐ 3. utilization management; and

☐ 4. member satisfaction surveys.

☐ ___ m. Evidence that recredentialing process includes an on-site visit to the offices of all primary care providers and OB/GYNs.

☐ ___ n. Copies of policies and procedures for reducing, suspending or terminating practitioner privileges.

☐ __ o. Evidence of oversight of any delegated credentialing/re-recredentialing activity to contractors including a written description of:

☐ 1. the delegated activities; and

☐ 2. the delegates accountability for these activities.

☐ __ p. Evidence that HMO monitors the effectiveness of the delegates credentialing and reappointment or recertification processes at least annually.

41. To establish that members rights and responsibilities are delineated in the quality process provide:

☐ ___ a. A copy of the HMOs written policy recognizing the right of members to:

☐ ___ 1. voice grievances about the HMO or care provided;

☐ ___ 2. have information concerning the HMO, its services, the practitioners providing care, and members rights and responsibilities;

☐ ___ 3. participate in decision-making regarding health care;

☐ ___ 4. be treated with respect and recognition of their dignity and need for privacy.

☐ __ b. A copy of the HMOs written policy addressing members responsibilities for cooperating with those health care providers by:

☐ ___ 1. giving needed information to professional staff to ensure appropriate care; and

☐ ___ 2. following instructions and guidelines given by health care providers.

☐ ___ c. A statement that the HMO provides a copy of policies on members rights and responsibilities to all participating providers and directly to members.

☐ __ d. Evidence that members are given a written statement including:

☐ ___ 1. The HMOs policy on referrals for specialty care;

☐ ___ 2. Provisions for after-hours and emergency coverage;

☐ ___ 3. Benefits and services included and excluded from membership:

☐ ___ a. any special benefit provisions (e.g., copayment, higher deductibles, rejection of claims) that may apply to services obtained outside the system; and

☐ __ b. the procedures for obtaining out-of-area coverage;

☐ ___ 4. Charges to members, if applicable, including:

☐ __ a. policy on payment of charges, and

☐ ___ b. copayments and fees for which the member is responsible;

☐ __ 5. Procedures for notifying those members affected by:

☐ ___ a. termination or change in any benefits

☐ __ b. termination of any services, or

☐ ___ c. termination of any service delivery office/site;

☐ __ 6. Procedures for appealing decisions adversely affecting the members coverage, benefits, or relationship to the organization;

☐ __ 7. Procedures for changing practitioners;

☐ __ 8. Procedures for disenrollment of nongroup subscribers;

☐ ___ 9. Procedures for voicing complaints and/or grievances and for recommending changes in policies and services;

☐ ___ 10. Points of access to primary care, specialty care and hospital services;

☐ ___ 11. Information on provider names, qualifications and titles;

☐ ___ 12. A copy of written policies and procedure pertaining to confidentiality; and

☐ ___ 13. A copy of member satisfaction survey in including an assessment of:

☐ __ a. patient complaints;

☐ __ b. requests to change practitioners and/or facilities; and

☐ __ c. disenrollments by members.

☐ ___ e. Evidence of oversight of any delegated member service activities to contractors including a written description of:

☐ ___ 1. delegated activities;

☐ ___ 2. delegates accountability for these activities;

☐ ___ 3. frequency of reporting complaints and grievances and member survey data;

☐ ___ 4. process by which the delegation will be evaluated;

☐ __ 5. approval of the delegates member services program; and

☐ __ 6. evaluation of regularly specified reports.

42. To establish that the HMO engages in preventive health services provide:

☐ a. A copy of practice guidelines for the use of preventive health services.

☐ b. Evidence that the HMO monitors, evaluates and takes action to improve a minimum of two of the following:

☐ Childhood immunizations:

☐ DTP (diphtheria and tetanus toxoids with pertussis vaccine);

☐ OPV (oral poliovirus vaccine);

☐ HIB (hemophilus influenza B conjugate vaccine);

☐ MMR (measles, mumps, and rubella vaccine); and

☐ Hepatitis B vaccine

☐ Adult immunizations:

☐ Influenza vaccine;

☐ Pneumococcal vaccine;

☐ Hepatitis B vaccine;

☐ Diphtheria and tetanus toxoid; and

☐ Rubella screening for women of childbearing age.

☐ Coronary artery disease risk factor screening and/or counseling:

☐ Smoking;

☐ Cholesterol;

☐ Exercise; and

☐ Hypertension.

☐ Cancer screening:

☐ Breast; and

☐ Cervix.

☐ Counseling for prevention of motor vehicle injury;

☐ Lead toxicity screening;

☐ Sexually transmitted disease screening/prevention;

☐ Prenatal care;

☐ Human immunodeficiency virus (HIV) screening/prevention;

☐ Prevention of unintended pregnancy; and/or O -- Alcohol and other drug abuse screening/prevention.

43. To establish that medical records are maintained in a manner that is current, detailed, organized, and permits effective patient care and quality review provide:

☐ __ a. A statement that records are available to health care practitioners at each encounter and to a nationally recognized reviewing body sanctioned by the Commissioner; and

☐ ___ b. A copy of standards for maintaining medical records.

XI. MISCELLANEOUS

☐ ___ 44. Submit a description of enrollee participation in matters of policy and operation.

☐ ___ 45. Submit the attached "ACKNOWLEDGMENT AND WAIVER OF CHIEF EXECUTIVE OFFICER ON BEHALF OF HMO APPLICANT"which shall contain notarized acknowledgements that:

☐ A delinquency proceeding or supervision by the Insurance Commissioner constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation.

- ☐ Waives any right to file or be subject to any federal bankruptcy proceeding.
- ☐ Comes from the CEO acknowledging that he/she has read and understands his/her obligations to report any impairment of the HMO to the Insurance Commissioner.

☐ ___ 46. Submit the attached "RESIDENT AGENT Form (IC-FC3O).

NOTICE

TO: ALL WEST VIRGINIA HEALTH MAINTENANCE ORGANIZATIONS

RE: AMENDMENTS TO CERTIFICATE OF AUTHORITY

DATE: MAY 11, 1995

Please take notice that a $200 filing fee is required by West Virginia Code § 33-25A-22 for each filing by a health maintenance organization requesting an amendment to such organizationss certificate of authority. A request for a service area expansion would be an example of such a filing. Health Maintenance Organization must attach the filing fee to the form entitled APPLICATION FOR AMENDMENT TO CERTIFICATE OF AUTHORITY FILING FEE REMITTANCE FORM ["HMO-COAAMEND-1"] for each such filing. This form is enclosed with this Notice. Additional forms may be requested from the Financial Conditions Divisions.

As of the date of this Notice, all requests for service area expansions, changes of corporate name, or other filings relating to the amendment of a certificate of authority, which are filed with the West Virginia Insurance Commission and do not have the required filing fee and remittance form attached thereto, will be rejected and returned to the health maintenance organization.

HANLEY C. CLARK
INSURANCE COMMISSIONER OF THE
STATE OF WEST VIRGINIA

STATE OF WEST VIRGINIA
INSURANCE COMMISSIONER

HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR AMENDMENT TO CERTIFICATE OF AUTHORITY
FILING FEE REMITTANCE FORM

West Virginia Code § 33-25A-22

NAME OF HEALTH MAINTENANCE ORGANIZATION: _____

_____

WEST VIRGINIA FILE NUMBER: _____

FEIN# _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

CONTACT PERSON: _____

PHONE NUMBER: _____

In reference to the submission of the above-referenced application for amendment to your existing Health Maintenance Organization Certificate of Authority in the State of West Virginia, it is necessary for this form to be returned to the address below with proper payment.

PLEASE NOTE:

1. Send a check in the amount of Two Hundred Dollars ($200.00), made payable to the West Virginia Insurance Commissioner. Mail application for amendment to the Health Maintenance Organization Certificate of Authority, check and remittance form to:

   West Virginia Insurance Commissioner
   Financial Conditions Division
   2019 Washington Street, East
   P.O. Box 50540
   Charleston, West Virginia 25305-0540

2. Include a copy of the check with the courtesy copy of your application for amendment to be forwarded to the West Virginia Health Care Cost Review Authority

OFFICE USE ONLY
FF_____
_____
(INITIALED)

STATE OF WEST VIRGINIA
INSURANCE COMMISSIONER

MINIMUM AMOUNTS OF FIDELITY INSURANCE
§ 33-25A

Exposure Index			Bracket No. *	Amount of Bond		
$ 1,000	-	$ 25,000	1	$ 15,000	-	$ 25,000
25,000	-	125,000	2	25,000	-	50,000
125,000	-	250,000	3	50,000	-	75,000
250,000	-	500,000	4	75,000	-	100,000
500,000	-	750,000	5	100,000	-	125,000
750,000	-	1,000,000	6	125,000	-	150,000
1,000,000	-	1,375,000	7	150,000	-	175,000
1,375,000	-	1,750,000	8	175,000	-	200,000
1,750,000	-	2,125,000	9	200,000	-	225,000
2,125,000	-	2,500,000	10	225,000	-	250,000
2,500,000	-	3,325,000	11	250,000	-	300,000
3,325,000		4,175,000	12	300,000	-	350,000
4,175,000	-	5,000,000	13	350,000	-	400,000
5,000,000	-	6,075,000	14	400,000	-	450,000
6,075,000	-	7,150,000	15	450,000	-	500,000
7,150,000	-	9,275,000	16	500,000	-	600,000
9,275,000	-	11,425,000	17	600,000	-	700,000
11,425,000	-	15,000,000	18	700,000	-	800,000
15,000,000	-	20,000,000	19	800,000	-	900,000
20,000,000	-	25,000,000	20	900,000	-	1,000,000
25,000,000	-	50,000,000	21	1,000,000	-	1,250,000
50,000,000	-	87,500,000	22	1,250,000	-	1,500,000
87,500,000	-	125,000,000	23	1,500,000	-	1,750,000
125,000,000	-	187,500,000	24	1,750,000	-	2,000,000
187,500,000	-	250,000,000	25	2,000,000	-	2,250,000
250,000,000	-	333,325,000	26	2,250,000	-	2,500,000
333,325,000	-	500,000,000	27	2,500,000	-	3,000,000
500,000,000	-	750,000,000	28	3,300,000	-	3,500,000
750,000,000	-	1,000,000,000	29	3,500,000	-	4,000,000
1,000,000,000	-	1,250,000,000	30	4,000,000	-	4,500,000
1,240,000,000	-	1,500,000,000	31	4,500,000	-	5,000,000

Calculation of Bond Amount

1. Total Admitted Assets
   $_____ x 5% = $ _____

2. Gross Income*
   $_____ x 10% = $_____
   Exposure Index = $ _____

3. Minimum Amount of Bond
   Bracket No. _____ $_____

*Include gross premium and written and assumed plus interest and dividend income.

RESIDENT AGENT

I, _____, a duly elected, qualified officer of the
(Name of Person, Please Print)
_____ do hereby certify that if the captioned
(Name of Company, Please Print)

company is successful acquiring an insurance license in the State of West Virginia, it agrees to observe the requirements for a licensed resident agent, including those related to counter-signature requirements, as provided for in Article 12, Chapter 33 of the West Virginia Insurance Code.

Subsequent to Company licensing, the Insurance Department will issue instructions as to the procedure for the licensing of agents.

Dated this _____ day of _____ , 19_____.
(Month)

_____
(Signature)

_____
(Title of Officer or Director, Please Print)

ACKNOWLEDGEMENT AND WAIVER BY CHIEF EXECUTIVE OFFICER ON BEHALF OF HEALTH MAINTENANCE ORGANIZATION APPLICANT

I, _____, the _____ [Chief Executive Officer] of _____ [HMO Applicant], hereinafter referred to as the "Organization", having the authority to bind said Organization, do hereby:

(1) ACKNOWLEDGE, on behalf of the Organization, that a delinquency proceeding brought pursuant to the provisions of Article 10, Chapter 33 of the West Virginia Code of 1931, as amended [W. Va. Code §§ 33-10-I et seq.], or the administrative supervision provisions of article thirty-four of said chapter [W. Va. Code §§ 33-34-1 et seq.] constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization licensed under the laws of this State; and

(2) WAIVE, on behalf of the Organization, any right to file or to be subject as a debtor to any bankruptcy proceedings;

(3) AFFIRM that I have read and do hereby understand the obligation imposed upon me as the chief executive officer of the Organization by the provisions of Article thirty-five of Chapter 33 of said Code [W. Va. Code §§ 33-35-1 et seq.] dealing with the criminal sanctions for the failure to timely report to the Insurance Commissioner an impairment of the Organization.

Dated this _____ day of _____ , 199___ .

_____
(HMO applicant)

BY: _____
(Signature)

ITS: _____
(Title)

State of _____,
County of _____, to wit;

I, _____, a Notary Public in and for the county and state aforesaid, hereby certify that _____ whose name is signed to the foregoing document, bearing date the _____, day of _____199__, for _____.
(HMO Applicant), has this day in said county, personally appeared before me in said county and acknowledged the said writing to be the act and deed of said corporation.

Given under my hand this _____, day of _____ , 199 ____.

My commission expires on _____.

(SEAL)

_____
Notary Public

RECOMMENDED HMO HOLD HARMLESS LANGUAGE

No Billing Of Members

1. **No Charges**. Participating Provider shall hold harmless and not impose any charges on HMO Members for Plan benefits and shall regard the HMO payment as payment in full for all benefits covered by this Agreement with the exception of co-payments specifically authorized in the applicable Evidence of Coverage and any non plan benefits. Participating Provider shall also be entitled to receive payment for third party claims. Participating Provider will never, under any circumstances, including non-payment by HMO, the insolvency of HMO, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any HMO Member for Plan benefits. Participating Provider shall look only to HMO for payment for plan benefits. If HMO receives notice that a Participating Provider has billed or collected from a Member for any covered or nonauthorized benefit, HMO may refund that amount to Member and may offset that amount from any payment to Participating Provider, with prior notice to the Participating Provider.

2. **No Collection Action Against Members**. Neither Participating Provider, trustees or assignees, may maintain any action at law against Member to collect sums owed by HMO.

3. **Survival of Covenants.** Participating Provider further agrees that these provisions shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member, and that these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participating Provider and Member or any persons acting on their behalf.

4. **Collections of Copayments**. These provisions shall not preclude Participating Provider from collecting the Co-payments that are specifically authorized by the Members Evidence of Coverage.

5. **Non-Covered Services.** A Participating Provider may bill a Member for services if: (i) prior to receiving such services the Member is advised that such services are not Covered Services; and (ii) after being so advised the Member nevertheless elects in writing to receive such non-Covered Services.

Provisions of the West Virginia Code (other that Article 25A) Applicable to Health Maintenance Organizations (HMO)

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